TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Kaufman

Respondent Name
East TX Educational Ins Assn

MFDR Tracking Number
M4-15-3589-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
June 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After the payment of $265.50, there is a balance of $887.18."

Amount in Dispute: $887.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We maintain our denial was correct based on NCCI Edits and at this time no further reimbursement is due."

Response Submitted by: Claims Administrative Services, Inc., 501 Shelley Drive, Tyler, TX 75701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2014	99285	$887.18	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or Workers Compensation State

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 236 – "This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state." 28 Texas Administrative Code §134.403 (d) requires that "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided." Review of the National Correct Coding Edits found at www.cms.hhs.gov, a coding conflict between codes 99285 and 94640 that was billed on the same date of service by the health care provider has been in effect since January 1, 2014. A modifier and documentation to support a separate and distinct procedure would have allowed separate payment. No modifier was used therefore the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.
2. Pursuant to Rule 134.403 (d) no payment is due for the service in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 28, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.